MDR Tracking Number: M5-04-2674-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-23-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the prescription medication Oxycontin dispensed from 12/16/03 through 1/20/04 was not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, the request for reimbursement for dates of service 12/16/03 through 1/20/04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day of July 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

June 22, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2674-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery and is familiar with the condition and treatment options at issue in this appeal. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review.

In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 34 year-old male who sustained a work related injury on ___. The patient reported that while at work the patient began to experience low back pain with right lower extremity pain. Initial treatment for this patient included physical therapy and a chiropractic care program. On 7/30/01 the patient underwent a MRI of the lumbar spine that was reported to have shown a disc herniation at L4-L5. From 8/23/01 through 10/11/01 the patient underwent a series of epidural steroid injections to the lumbar spine and continued physical therapy and chiropractic management. On 1/4/02 the patient underwent a right L4-L5 hemilaminectomy, foraminotomy, and discectomy. Following the surgery the patient was treated with postoperative physical therapy. A repeat MRI of the lumbar spine on 8/9/02 was reported to have shown a recurrent right central disc protrusion with compression of the right L5 root and a further MRI performed on 6/2/03 was reported to have revealed a recurrent disc protrusion at L4-L5. The patient was taken to surgery on 8/15/03 for a re-do right L4-L5 hemilaminectomy, foraminotomy, and discectomy, 360 degree fusion through a posterior approach, posterolateral fusion at L4-L5, and posterolateral segmential instrumentation. The patient has also been treated with pain medications and antidepressants.

Requested Services
Oxycontin from 12/16/03 through 1/20/04

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Follow up office visit note 2/19/04
2. Letter of Medical Necessity 4/27/04

Documents Submitted by Respondent:

1. Retrospective Peer Review 9/30/03.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 34 year-old male who sustained a work related injury on ___. The ___ physician reviewer also noted that treatment for this patient has included chiropractic care, physical therapy, epidural steroid injections, surgery, and oral pain medications. The ___ physician reviewer further noted that the patient had been treated with oral oxycontin from 12/16/03 through 1/20/04. The ___ physician reviewer explained that the documentation provided did not show medical necessity for this patient's treatment with oxycontin. The ___ physician reviewer also explained that the documentation provided did not show that the patient had tried and failed a pain management program from 12/16/03 through 1/20/04. The ___ physician reviewer further explained that the documentation provided did not show evidence of a causal link between original injury and the subsequent development of pain tolerance requiring oxycontin. Therefore, the ___ physician consultant concluded that the prescribed oxycontin from 12/16/03 through 1/20/04 were not medically necessary to treat this patient's condition.

Sincerely,